STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaints IN00098337, IN00098510, and IN00098605. IN00098337-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F441. IN00098510-Substantiated. Federal/state deficiency related to the allegations is cited at F 282. IN00098605-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F441. Survey dates; October 31 2011 and November 1, 2, 2011 Facility number: 000459 Provider number: 155567 Aim number: 100289700 Survey team Ann Armey, RN TC Ellen Ruppel, RN Census bed type: SNF: 10 SNF/NF: 73 Total: 83	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Census payor type: Medicare: 10 Medicaid: 44 Other: 29 Total: 83 Sample: 13 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/3/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. Based on observation, interviews and record review, the facility failed to follow the physician's orders regarding the oxygen flow rates for 2 of 3 residents receiving continuous oxygen in a sample of 13. (Residents I and K) 2. Based on record review and interviews, the facility failed to follow the physician's orders for the application of medication for skin rash for 1 of 6 residents treated for skin rashes in a sample of 13. (Resident B)	F0282	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.F-282 1. Facility had no opportunity to correct for Resident I and K because they no longer reside in the facility. The physician for	12/02/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. a. Review of the closed clinical record of Resident I, on 10/31/11 at 2:30 p.m., indicated the resident had been admitted to the facility, on 8/13/11, with diagnoses including, but not limited to: end stage congestive occlusive pulmonary disease (COPD) and chronic respiratory failure. Physician's orders, dated 9/12/11, indicated the resident was to have oxygen at 5 liters per minute through a nasal canula, continuously. This order was in effect on 10/15/11, when the resident became short of breath and requested being sent to the hospital. Review of the nurses note, dated 10/15/11 a late entry for 9:20 a.m., indicated the resident had been found to have a blood oxygen level of 81% and the oxygen flow rate had been running at 3 liters a minute. This was 2 liters less than had been prescribed. During an interview with LPN #6, on 11/2/11 at 7:10 a.m., she indicated she had been working the day Resident I was sent to the hospital. She indicated she had been on another unit, but came to help with the transfer when the nurse working on the unit needed help. LPN #6		Resident B was contacted and an order was received to D/C the Permethrine treatment to be administered on 10/31/2011.2. Residents in house were assessed (see attachment A). Any residents that were identified with a rash were assessed by the nurse practioner, and appropriate treatment obtained as indicated. An in house audit of resident's oxygen orders was completed to assure correct flow rate was identified (see attachment B).3. Staff reeducation will be completed for licensed nurses on proper transcribing of orders (see attachment C), and identification of rashes and typical treatment of rashes (see attachment D).4. Physician orders will be monitored via the Daily Medical Records/DNS report (see attachment E). Oxygen will be monitored via the Oxygen Flow Sheet (see attachment F) 3 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 months (total increased monitoring for 6 months), then quarterly. Results will be reviewed in QA meetings with a subsequent plan developed, and implemented as indicated.5. Actions will be completed by 12/02/2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she had gone into the resident's room and noticed the oxygen was flowing at 3 liters a minute and she started a Duoneb breathing treatment for the resident. She indicated she stayed with the resident until the unit nurse (RN #5) could come back and stay with the resident. LPN #6 indicated she then left the room to complete the transfer paper work. She indicated she had not changed the liter flow of the oxygen. During an interview with RN #5, on 11/2/11 at 12:45 p.m., she indicated she had been in the dining room and returned to the unit "around 8:30 a.m.," on 10/15/11, when CNA #7 came to her and told her Resident B was having trouble breathing. RN #5 indicated she did not check the oxygen flow rate and was unaware it was running less than the ordered 5 liters per minute. She indicated she had LPN #6 complete the transfer papers and the ambulance arrived at 9:00 a.m. She indicated family had been notified, but had not arrived until the ambulance was in the building. She indicated she had not changed the liter flow of the oxygen. During an interview with CNA #7, on 11/2/11 at 1:05 p.m., she indicated she had gone into Resident I's room the morning of 10/15/11 and found the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident having difficulty breathing. CNA #7 indicated she used the resident's phone to call the grand daughter when the nurse was unable to reach a family member on the facility phone. CNA #7 indicated the resident was alert and had told her to use her phone to call the family and tell them she wanted to go to the hospital. CNA #7 indicated she left the room when the nurse arrived and she had not changed the oxygen flow. She also indicated she had not noticed what the rate had been set on when she was in the room. Review of the ambulance report indicated the resident's blood oxygen saturation level was 82% at 9:06 a.m., on 10/15/11 and went up to 94 % by 9:22 a.m. when the oxygen flow rate was increased to 6 liters per minute by ambulance crew. She was then transported to the emergency room and the oxygen flow rate had been decreased to 4 liters per minute, with the blood oxygen level remaining at 94% on the 4 liter flow. b. Review of the clinical record of Resident K, on 11/2/11 at 5:40 a.m., indicated the resident had been admitted to the facility on 9/24/11. His diagnoses included, but were not limited to: lung cancer with metastases and pleural effusion.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician's orders, dated 9/25/11, indicated oxygen was to be run at 4 liters per minute continuously via nasal canula. Nurses notes, of 9/25, 9/26, 9/27, 9/28, and 9/29/11, indicated the oxygen was being run at 3 liters per minute, rather than the 4 liters which were ordered. The blood oxygen levels were recorded as being above 90% on all days. The October 2011 recapitulation of orders had an entry indicating 3 liters per minute of oxygen and the physician had signed the sheet. The order from 9/25 to 9/30/11, had been for 4 liters. The facility had been running one liter less than what was ordered for six days. The oxygen flow rate was observed, on 11/2/11 at 6:05 a.m., running at 3 liters per minute. 2. Review of the clinical record of Resident B, on 10/31/11 at 10:15 a.m., indicated the physician had ordered Permethrine 5% creme to the whole body and a repeat treatment in 10 days. This treatment was for suspected scabies. The Medication Administration Record (MAR) for October 2011, indicated the Permethrine was applied on 10/3/11, but the 10 day repeat was not done until			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/21/11. The 10 day repeated treatment would have been due 10/13/11. The MAR indicated the Permethrine was being applied by nurses daily from 10/5 to 10/28/11. The Director Of Nursing (DON) was queried, on 11/1/11 at 10:00 a.m., about the daily entries and the span of time between the two ordered treatments of the scabies-like rash on Resident B. She indicated the applications were not applied at the 10 day span as ordered and the daily initials on the MAR did not mean the resident was being treated daily with the Permethrine creme. She indicated the entries were to indicate the monitoring of the areas. Resident B was interviewed, on 10/31/11 at 11:30 a.m., about the rash and treatments for it. He had been identified as interviewable during the orientation tour on 10/31/11 at 9:20 a.m., by the DON. The resident indicated he had been treated two times of the rash and continued to "itch" from the areas on his body. This federal tag relates to Complaints IN00098605, IN00098510 and IN00098337. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interviews and record review, the facility failed to establish and implement policies regarding the treatment of suspected scabies. This deficient practice had the	F0441	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the	12/02/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	potential to affect 83 of 83 residents residing in the facility. (Residents F, C and N) Findings include: 1. During interview, on 10/31/11 at 10:15 a.m., LPN #1 indicated the facility had two out breaks of scabies but the facility did not inservice staff or provide information about what they should be doing to protect residents and staff. During interview, on 10/31/11 at 1:20 p.m., CNA #2 indicated many residents had rashes and the staff were not wearing gowns or gloves. The CNA indicated a staff person went to the hospital with a rash and received a diagnosis of scabies but they were told not to discuss this. The CNA indicated she had not received any inservice training about the rashes or scabies. 2. On 10/31/11 at 1:30 p.m., the DON (Director of Nursing) provided a list of eight residents who had rashes in October 2011. The DON indicated the residents were being treated prophylactic for possible scabies. The clinical record of Resident #F was reviewed on 10/31/11 at 2:55 p.m., and indicated the resident was admitted to the		provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.F-4411. Facility had no opprotunity to correct for Resident F because resident no longer resides at the facility. Residents C and N have been assessed (see attachment A), and the appropriate treatment identified and treatment given as ordered.2. All residents have the potential to be affected.3. Staff was reeducated on infection control policies (see attachment B) related to skin conditions.4. The DON/designee will perform audits of staff adherence to infection control practices (see attachment C) of 2 staff 3 times a week x 4 weeks. then 2 staff weekly 4 weeks, then 2 staff monthly x 4 months, then quarterely thereafter. This monitoring will occur on all 3 shifts. Results will be reviewed in QA meetings with a subsequent plan developed, and implemented as indicated.5. Actions will be completed by 12/02/2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility on 1/21/11 with a diagnoses which included but was not limited to, dementia. Physician progress notes, dated 8/12/11, indicated the resident had a rash with itching on her inner thighs, back and buttocks. The note indicated "clinically scabies-typical tracks on low back." Physician orders, dated 8/12/11, indicated "Permethrin 5% cream (a topical cream used to treat scabies) apply /rub in all over body- wash off next morning-repeat in 2 wks (weeks). wash all clothing/ bedding-day after application." The August 2011 MAR (Medication Administration Record) indicated the Permethrin cream was applied on 8/12/11 and reapplied on 8/27/11. 3. On 11/1/11 at 9:30 a.m., the DON indicated they did an inservice on hand washing on 10/19/11, but did not have an inservice regarding the identification, transmission, prevention and treatment of scabies until 11/1/11. The DON indicated the facility's Nurse Practitioner had developed the inservice and they were in the process of training the staff. The DON indicated the staff were to wear gown and gloves when they applied the Permethrin cream as well as, when they showered the resident before and after the application of the cream. 4. During an interview with the family			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member or Resident # C, on 11/1/11 at 11:30 a.m., the family member indicated he had a rash on his arms and had gone to his family physician for treatment. He pulled up his shirt sleeve and pointed to reddish areas on both arms and indicated he was not sure what had caused the redness. He indicated the physician had ordered "pills" and ointment, but had given him no exact diagnosis of the areas. Observation of CNA#4, during the bathing/ shower of Resident C, on 11/1/11 at 11:55 a.m., during the wash-off of the Permethrin, the aide was wearing gloves during the procedure, but no gown. The resident had tiny red blotches with some scabbing present covering the entire body. 5. On 11/1/11 at 2:30 p.m., the Infection Control Nurse was interviewed. She indicated she had not been tracking the incidences of rashes/ possible scabies. As a result, she had no information about the location, trends or repeat incidences of rashes. She indicated she could check the charts to determine which residents had rashes and which residents received treatments for scabies over the last several months. She indicated staff had not been screened for rashes. The Infection Control Nurse further indicated there was no interdisciplinary infection control			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	committee, which included staff from various departments. 6. On 11/2/11 at 5:00 a.m., the clinical record of Resident # N was reviewed and indicated the resident was initially admitted to the facility on 3/24/09. The Minimum Data Set (MDS) Assessment, dated 10/9/11, indicated the resident had no cognitive impairments. Physician progress notes, dated 8/23/11, indicated the resident was seen for complaints of "itching all over c (with) rash." Physician progress notes, dated 10/18/11, indicated the resident had a maculopapular rash to the bilateral upper extremities, groin and hands with burrowing noted to the lower legs, groin, and hands. Medication Administration Records indicated the resident received a treatments with Elimite/Permethrin (a cream used to treat scabies) on 8/23/11, 10/18/11 and 10/31/11. During an interview with Resident N, on 11/2/11 at 9:30 a.m., he indicated he had been itching and was constantly scratching. He added, "it's miserable" and the most recent treatment had been done on 10/31/11. 7. On 11/2/11 at 10:00 a.m., the Infection Control Nurse indicated , after a number of rashes developed in October 2011, she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	made an action plan to inservice staff regarding hand washing and this was done on 10/19/11. She further indicated weekly skin checks were being done by the nurses and yesterday, 11/1/11, training had begun regarding the identification of rashes. The Infection Control Nurse indicated on 11/1/11, she had identified and mapped the locations of residents who had rashes that had been treated for possible scabies since May 2011. According to the maps, reviewed with the Infection Control Nurse, the number of residents with rashes who were treated for possible scabies were as follows: May 2011, 2 residents, June 2011, no residents, July 2011, 5 residents, August 2011, 2 residents, September 2011, 1 resident, October 2011, 10 residents. The maps indicated 13 of the "rashes" occurred on the 200 hall, 4 on the 100 hall and 3 on the 300 hall. 8. On 11/2/11 at 1:00 p.m., the Nurse Practitioner was interviewed. She indicated on 10/18/11, she was notified about the rashes and either interviewed or screened every resident on the 200 hall for signs of scabies. She indicated several residents had rashes that had characteristics of scabies and as a result, all residents with rashes were treated for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	possible scabies. She indicated all staff were offered treatment if they had rashes or concerns. 9. The policy for the "Care Of Residents With Scabies", revised in 2004, provided by the DON, was reviewed on 11/2/11 at 1:15 p.m. and indicated, in part, "... All suspected or diagnosed cases should be reported to the Infection Control Practitioner.. Scabies is an infectious disease of the skin caused by Sarcoptes scabiei or itch mite... Treatment of scabies must be ordered by a physician... Before starting treatment, explain to patient, family members (if possible) and health care workers what the problem is and how it is transmitted from person to person. Educate patient, family and staff ... Precautions for employees consists of wearing gloves and gowns if in close contact with infested person or things...This is necessary before treatment and for 12-24 hours after treatment..." This Federal tag relates to Complaint IN00098605 and IN00098337. 3.1-18(b)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	11/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE